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ABSTRACT

This paper details a project in which a counselor educator and 12 counseling graduate students, trained in child-centered play therapy, worked in an inner city school with 4th-6th grade students during the 1996-1997 academic year. The play therapy training undergone by the graduate students and the facility used for the therapy sessions are described. The paper presents issues in establishing the program. The following conclusions were drawn from the year-long experience: (1) working with at-risk children has the obvious advantage of access to the children, because they are in school for many days making it possible for counselors to reach children who would not attend counseling outside school; (2) play did seem to be an effective approach with these older at-risk children; (3) most of the children demonstrated interest in exploring a variety of the toys; and (4) child-centered play therapy was well accepted by these students. Communication with administrators, teachers and parents to help them understand more about play therapy and its value is essential; privacy is critical; and because the word "play" created difficulties, using the words "counseling" or "developmental counseling" may make the sessions seem more important to others. (MKA)

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Running Head: PLAY THERAPY WITH AT-RISK CHILDREN

Child-Centered Play Therapy: Working With At-Risk Youth In The Elementary School Setting

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Child-Centered Play Therapy: Working With At-Risk Youth In The Elementary School Setting

The purpose of this article is to describe a project undertaken to implement child-centered play therapy with at-risk 4th, 5th, and 6th graders.

Child-Centered Play Therapy: Working With At-Risk Youth In The Elementary School Setting

Societal changes over the last three decades have increased the importance of attaining a high school degree. Rumberger (1987) reports that today's high school dropouts are more likely to face unemployment, lower earning potential, and an increase in medical, psychological and emotional problems as compared to dropouts of the past. It is crucial to identify and assist these students at risk of dropping out during the elementary years (Bloom, 1981; Gage, 1990; Mann, 1986). A profile of the at-risk child has revealed that minority cultural status and low socioeconomic status are major characteristics found within this populations (Mare, 1980; Steinberg, Blinde, & Chan, 1984). Clearly, a need for culturally sensitive counseling strategies appropriate for elementary aged at-risk students exists.

Because of their cognitive level of development, elementary school-aged children are unable to work through personal struggles through verbal expressions. According to Axline (1947), and more recently Landreth (1991), play is the child's natural medium for self-expression. In addition to communicating in a way that is consistent with the child's developmental level, this de-emphasis on verbal expression also enables the counselor to overcome communication barriers that may result from cultural differences (Cochran, 1996). Play therapy is an ideal approach to meet this need. The wisdom of using play therapy as the intervention of choice in elementary schools is increasingly evident in the literature (Campbell, 1993; Johnson, McLeod, & Fall, 1997; Landreth, 1993).

In this project, a counselor educator and 12 counseling graduate students, trained child-centered play therapy, worked in an inner city upper elementary school for 10 to 20 hours per week for the 1996-1997 academic year. The article will describe the school population, the play therapy training, the facility, issues in establishing the program, and conclusions.

The School Population

The school was composed of about 180 4th, 5th, and 6th grade boys and girls who attended an inner city school in a southeastern city with a population of approximately 400,000 residents. Fifty nine percent of the students were male, and 41% of the students were female. Students ranged in age from 9 to 12, with a mean age of 10. Eighty two percent of the students were African-American, 8% were white, 7% were Asian, and 3% were "other." Approximately 95% of the students were eligible for free or reduced lunch. Thirty nine percent of the students lived only with their mother, 34% lived with their mother and father, 9% lived with their grandmother, 10% lived with their mother and another person, and the remaining 8% lived in other configurations. Forty-six percent of the children in the school participated in play therapy. Referrals to play therapy were made by teachers and parents. The number of play therapy sessions ranged from 1 to 25, with a mean number of 4 sessions.

The Play Therapy Training

The objective of the counselors was to closely follow the Landreth's model of child-centered play therapy, as described in Play therapy: The art of the relationship (Landreth, 1991). All of the counselors had completed a graduate level course titled "Introduction to Play Therapy." The course included didactic instruction, observations of children at play, practice through role playing with other students, and experience conducting play sessions with elementary school aged children in a school setting.

In describing his orientation towards children and counseling, Landreth states,

> "Child centered play therapy is not a cloak the play therapist puts on when entering the playroom and takes off when leaving; rather it is a philosophy resulting in attitudes and behaviors for living one's life in relationships with children. It is both a basic philosophy of the innate human capacity of the child to strive toward growth and maturity and an

> attitude of deep and abiding belief in the child's ability to be constructively self-directing.
>
> The child-centered play therapist believes deeply in and trusts explicitly the inner person of the child. Therefore, the play therapist's objective is to relate to the child in ways that will release the child's inner directional, constructive, forward-moving, creative, self-healing power. When this philosophical belief is lived out with children in the playroom they are empowered and their developmental capabilities are released for self-exploration and self-discovery, resulting in constructive change. The impact of living out this kind of relationship was described by a child as, 'Who would have though there was a place like this in the whole world! In here you can just be your own little ol' self' (Landreth & Sweeney, 1997, p. 17)."

Thus, the goal was to create a therapeutic environment through using materials in the playroom in a child-centered way of being with the children. Landreth (1991) emphasizes that toys which are most helpful to children are those that encourage the expression of a wide range of feelings, an exploration of real life experiences, the opportunity to test limits, the development of positive self-image, the development of self-understanding, and the development of self-control. Three categories of toys include real-life toys (e.g., doll family, doll house, puppets, nondescript figures, car, truck, boat, cash register), acting out or aggressive-release toys (e.g., bop bag, toy soldiers, alligator puppet, guns, rubber knife, and animal toys), and creative expression or emotional release toys (e.g., sand, water, play doh, and blocks). Toys for this project were selected from these three categories.

The Facility

Two rooms in a trailer behind the school were furnished as playrooms. The rooms were about 10 feet by 10 feet square, had small windows (with bars across them), and

were connected with a door. To enter Playroom 2, one had to walk through Playroom 1. Thus, privacy was compromised in the space provided. The floors were vinyl, which facilitated cleaning them. The school provided shelving, tables, chairs, a chalk board, paper, pencils and a small budget to replace play materials. The remaining toys were donated from students or purchased from stores or yard sales.

Issues in Establishing The Program

The concept of play therapy was new to the teachers, parents, and students. The greatest challenge, by far, in establishing the program was "selling" the concept of child-centered play therapy. While the faculty described serious problems experienced by many of the children, such as unstable home situations, high levels of anger/aggression in the school and classroom, and many learning/academic problems, many found it difficult to allow students, who needed so much academic support, to leave their classrooms to "just play." Many teachers expressed that they could understand and appreciate more directive approaches to helping these children, such as reality therapy or behavioral contracting. This experience highlighted the need to educate teachers about play therapy before implementing such a program.

A second issue was whether the children aged 11 and 12 would feel comfortable using the play materials, given that the materials are generally used with children aged 10 and younger (Landreth & Sweeney, 1997). Thus, there was some questions about whether these children would find the toys too "babyish" and feel uncomfortable becoming involved with them.

Another issue was parental understanding of child-centered play therapy. Many parents needed help to understand that real life issues would emerge in a "play" room and that children would work on these issues through a counseling approach using play with toys. For example, one parent who was having difficulty understanding how a child-centered approach could help her 200 pound, 12 year old son, was astonished when the counselor asked her if she was having any difficulty with her son "pushing her to the

limit," or "seeing how far he could go and get away with things." This child's persistent behavior in the playroom included pouring sand to the top edge of containers, parading around the room with the sand-filled containers, and mixing together all of the colors of play doh. While these behaviors in the playroom were not shared with the parent to protect the child's confidentiality, after talking with the counselor, the parent realized that through in the playroom, her son was actually working on issues that were central, at that time, to his growth and development.

Another issue was including aggressive release toys, specifically the guns, in the school playroom. The school was committed to creating a "peaceful" environment, particularly given the chaotic living situations of some of the children. This was highlighted when one of the graduate student interviewed some children in a school. When asked about their biggest fears, a universal concern of these children was for their personal safety in their own neighborhoods. Some students mentioned fear of gangs, and one child was anxious because of having witnessed a rape. Therefore, it was not surprising that the school administrators were apprehensive about the wisdom of including aggressive release toys. However, through providing information that it is healthy for the children to deal with their aggressive feelings in a safe environment and that children will act out aggression whether there are aggressive release toys or not, the administrators did permit the inclusion of aggressive release toys in the playrooms.

Conclusions

A number of conclusions relevant to school counselors can be drawn as a result of this year long experience conducting play therapy with at-risk 4th, 5th, and 6th grade children. First, working with at-risk children in a school setting has the obvious advantage of access to the children, because they are in school for many days. Therefore, school counselors can access many children who would not attend counseling outside the school. Also, it was possible to "catch up" with them at other times, when the children were unable to attend regularly scheduled sessions.

Play did seem to be an effective approach with these "older" at-risk children. The categories of toys Landreth (1991) suggests worked well with this population and age group of children. Children frequently selected the culturally appropriate toys, such as African American and Native American dolls/families and multicultural markers providing a variety of colors similar to varied skin shades. Perhaps, the toys were appropriate for this "older" population, because many of these children did not have these toys in their homes. Many children spoke of this during this sessions. One child talked of never having used water colors, and she painted with them during almost every one of her 18 sessions.

Also, most of the children demonstrated interest in exploring a variety of the toys. The way that the children played with the toys was not gender stereotyped. Boys cooked. Girls drove trucks. Boys fed babies with a bottle. Girls played with the handcuffs. The children used the aggressive release toys repeatedly. The handcuffs were one of the most popular toys. The sand box (a plastic container with dimensions of about 18 by 36 inches) was the central location of much of the aggressive play. Children used army figures, animals, and cars in the sand to express aggressive feelings.

The child-centered play therapy approach was well accepted by these students. An example illustrates this. One child was referred for counseling by a teacher who reported that his behavior was unacceptable in the classroom. The teacher suggested the counselor use a behavioral contract with the child. The counselor worked with the child to develop a contract, but the child was not involved in the counseling process and did not follow through on the identified behaviors. After 3 sessions, the counselor took the child to the playroom. The child immediately became involved in the process, played with the toys, and developed a relationship with the counselor. According to the teacher, his classroom behavior improved.

All of the graduate student counselors in this project were white. Over 80% of the children in the school were African American. When the graduate students were in the school, many children begged to go them to the playroom. Given that children between

the ages of 9 and 12 are beginning to search for their personal identity, which includes their cultural/ethnic identity, the universality of the child-centered approach to counseling, was consistent with Landreth and Sweeney's (1997) comments about working with children from different socioeconomic and ethnic backgrounds:

> "The child-centered approach is uniquely suited for working with children from different socioeconomic strata and ethnic backgrounds since these facts do not change the therapist's beliefs, philosophy, theory, or approach to the child. Empathy, acceptance, understanding, and genuineness on the part of the therapist are provided to children equally, irrespective of their color, condition, circumstance, concern or complaint. The child is free to communicate through play in a manner that is comfortable and typical for the child, including cultural adaptations of play and expression" (Landreth & Sweeney, 1997, p. 25).

Communication with administrators, teachers, and parents to help them understand more about play therapy and its value is essential. Without the acceptance of teachers and parents, it is impossible to access the children at the elementary school level. The importance of structuring time for discussions about the process, demonstrations of play therapy, and frequently scheduling conferences about student progress, while maintaining confidentiality with the child, cannot be over-emphasized. In addition, although maintaining regular contact parents is not as easy in a school as it is in an agency setting where a the parent often brings the child to sessions, maintaining consistent communication with the parents is also essential to help them understand the process and value the experience for their children.

Privacy in the playroom is critical. As mentioned above, the playrooms were in a trailer. The counselors walked through Playroom 1 to access Playroom 2. If there was a counseling session going on in Playroom 1, it was extremely disruptive. Also, the walls in the trailer were not soundproof. Students were often conscious not only of who was next

door in the playroom, but they could easily hear what the child in the next playroom was saying. There were times when children in different sessions would talk to each other through the wall. Therefore, carefully selecting appropriate space for the playroom is important. If this is impossible, helping to structure the experience for the children is necessary. For example, the counselor could say, "James, during our session today, someone may walk through this office. When this happens you may continue playing as you were before the interruption."

Finally, because the word "play," itself, created difficulties (some adults questioned the wisdom of sending children who were acting out in the classroom to "play"). Perhaps using the words "counseling" or "developmental counseling" would give administrators, teachers, or parents, the feeling that children "work" in play therapy and that it is important and serious.

In conclusion, it is clear that we must do something to help at-risk children develop the inner strength and confidence needed to facilitate their development. Child-centered play therapy engaged the children in a way that confirmed, once again, the critical importance of the therapeutic relationship and the power of helping children feel valuable and respected. Areas for further study are determining the impact not only of working with the children, but of training parents and teachers to use the skills of play therapy with at-risk children and determining the long range impact of play therapy with at-risk children. At-risk children need the attention of school counselors to give them greater promise for their futures. And play therapy is one appropriate way to work with these children.

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